



TRICARE Prime

Enrollment Application

How to enroll in TRICARE Prime

1. Review your DEERS information with the military personnel office, or call (800) 538-9552. It is important that your family member's names, addresses and other applicable information is correct in DEERS, or your application may be delayed.
2. On page 3, you will find the TRICARE Prime Enrollment Application. **Sponsor Information:** Please be sure all information regarding you or your sponsor is accurate and **complete**. A Primary Care Manager (PCM) must be selected. Review your Network Provider Directory or Primary Care Manager Assignments at the Military Treatment Facility (MTF), as applicable, for important information regarding your PCM selection. Call first to ensure that your choice of PCM is accepting new patients.
3. **Family Member Information:** Please provide us with information about the family members you wish to enroll in TRICARE Prime. Be sure all of the information is complete and accurate. Indicate a PCM choice for each family member enrolling.
4. If you are a retiree or family member of a retiree, and wish to pay your enrollment fee by check or credit card, indicate this choice under Payment Method. A payment schedule is provided in this section for those who wish to pay quarterly. If paying by credit card, remember to include your credit card number, the expiration date, name on the card, and signature.
5. Please answer the questions under Beneficiary Information Requested on page 4, paying special attention to question 1 concerning Other Health Insurance. Your input is valuable to the TRICARE Program.
6. On page 4, read and initial each item under Beneficiary Agreement to show you understand your role in the TRICARE program.
7. If you have other health insurance, please complete the Other Health Insurance Questionnaire on page 2.
8. SIGN AND DATE THE APPLICATION.
9. KEEP A COPY FOR YOUR RECORDS AND RETURN THE ENROLLMENT FORM TO:

Attention: Region 6
HNFS, Inc.
File #72862
P.O. Box 60000
San Francisco, CA 94160-2862
(with fee payment)

Attention: Region 6
HNFS, Inc.
P.O. Box 2890
Rancho Cordova, CA 95741-2890
(without fee payment)

Please keep in mind:

Be sure to fill out the application completely and accurately.

If your enrollment application and any applicable enrollment fees are received by the 20th of the month, your enrollment will become effective on the first day of the month following the month in which the application was received. All applications received after the 20th of the month will become effective on the first day of the second month after it is received.

Starting October 1, 2000, when an active duty member's retirement is effective other than the first of the month, he or she can enroll in TRICARE Prime in a retired status with no break in coverage. Also, when an active duty service member separates other than on the first of the month, but continues to be eligible (for example, is the spouse of an active duty service member or is eligible for the Transition Assistance Management Program), he or she can enroll in TRICARE Prime with no break in coverage. You must submit your application within at least one day of your retirement (or separation) date for no gap in coverage to occur. Any applicable enrollment fee will be collected at the time of enrollment.

The TRICARE Prime enrollment application must be signed by either the sponsor, spouse, or other legal guardian of the family member being enrolled.





Health Net Federal Services TRICARE Other Health Insurance Questionnaire

Do you or any member of your family have any Other Health Insurance coverage or have you had Other Health Insurance in the last 12 months?				
<input type="checkbox"/> YES <input type="checkbox"/> NO				
<i>If YES, please complete the following for <u>each insurance policy</u>. THIS FORM MAY BE COPIED</i>				
Type of coverage:				
<input type="checkbox"/> HMO/PPO <input type="checkbox"/> Single <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Supplemental <input type="checkbox"/> Medicaid <input type="checkbox"/> Other				
Policy Holder's Name:			SS #:	
Name of Insurance Company:				
Insurance Company's Address / Phone Number:				
Policy / Group / Plan Number:		Effective Date:		Expiration Date:
Does this Policy provide Pharmacy, Dental, Mental Health, or Durable Medical Equipment (DME) benefits? (Circle all that apply)				
Please list who is covered by this policy				
Name	Sex	Relationship to Policy Holder	Date Of Birth	SS#
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
(If additional people are covered please attach a separate listing. This form may be copied.)				
The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.				
_____	_____	_____	____/____/____	_____
Signature	Sponsor's SSN	Relationship to Sponsor	Date	

KEEP A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL WITH YOUR TRICARE PRIME ENROLLMENT APPLICATION.

Privacy Act Statement

(1) Authority: 5 USC 552a; 10 USC 1079 and 1086, 58 FR 45318. (2) Purpose: To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR, Part 199.17). (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

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CHECK ALL THAT APPLY:

- ☐ Transferring from another Region
 Region Number: ☐ Initial enrollment
☐ Former spouse ☐ Active to retired
☐ Split enrollment

TRICARE Prime Enrollment Application

Please use ink when completing this application, and print all information. Fill out all sections completely. Incomplete information may delay the enrollment process. If you have any questions about completing the application, call your TRICARE Service Center at (800) 406-2832.

Before completing this application, verify that you and your family's information is correct in DEERS. If the information is not correct, your enrollment will be delayed.

SECTION 1: SPONSOR INFORMATION

SPONSOR NAME		LAST		FIRST		MI		SPONSOR'S SOCIAL SECURITY NUMBER					
STREET				(NOT A P.O. BOX)		APT. NO.		CITY		STATE		ZIP	
SEX <input type="checkbox"/> M <input type="checkbox"/> F		BIRTHDATE MO. DAY YR.		PHONE HOME: () WORK: ()				OTHER DAYTIME PHONE ()		IS SPONSOR ACTIVE-DUTY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
SPONSOR'S RANK		SPONSOR'S PAY GRADE		UNIT OF ASSIGNMENT		SPONSOR'S WORK ZIP CODE		BRANCH OF SERVICE <input type="checkbox"/> USAF <input type="checkbox"/> USPHS <input type="checkbox"/> NOAA <input type="checkbox"/> US ARMY <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> USCG <input type="checkbox"/>					
IS SPONSOR AN ACTIVE-DUTY RESERVIST? <input type="checkbox"/> YES <input type="checkbox"/> NO								MO. DAY YR.		IS SPONSOR DECEASED? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE			
IF YES, INDICATE SEPARATION DATE													
IS SPONSOR RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS RETIRED SPONSOR ENROLLING? <input type="checkbox"/> YES <input type="checkbox"/> NO				IS TAMP ELIGIBLE SPONSOR ENROLLING? <input type="checkbox"/> YES <input type="checkbox"/> NO							
LIST PRIMARY CARE MANAGER NAME/CLINIC SITE COMPLETE ADDRESS										IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			

SECTION 2: FAMILY MEMBER INFORMATION

NAME		LAST		FIRST		MI		RELATIONSHIP TO SPONSOR		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS				(NOT A P.O. BOX)		CITY		STATE		ZIP	
MAILING ADDRESS				CITY		STATE		ZIP		PHONE HOME: () WORK: ()	
PRIMARY CARE MANAGER (PCM) MUST BE COMPLETED				NAME/CLINIC SITE				IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY CARE MANAGER'S ADDRESS				CITY		STATE		ZIP			
NAME		LAST		FIRST		MI		RELATIONSHIP TO SPONSOR		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS				(NOT A P.O. BOX)		CITY		STATE		ZIP	
MAILING ADDRESS				CITY		STATE		ZIP		PHONE HOME: () WORK: ()	
PRIMARY CARE MANAGER (PCM) MUST BE COMPLETED				NAME/CLINIC SITE				IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY CARE MANAGER'S ADDRESS				CITY		STATE		ZIP			
NAME		LAST		FIRST		MI		RELATIONSHIP TO SPONSOR		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS				(NOT A P.O. BOX)		CITY		STATE		ZIP	
MAILING ADDRESS				CITY		STATE		ZIP		PHONE HOME: () WORK: ()	
PRIMARY CARE MANAGER (PCM) MUST BE COMPLETED				NAME/CLINIC SITE				IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY CARE MANAGER'S ADDRESS				CITY		STATE		ZIP			
NAME		LAST		FIRST		MI		RELATIONSHIP TO SPONSOR		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS				(NOT A P.O. BOX)		CITY		STATE		ZIP	
MAILING ADDRESS				CITY		STATE		ZIP		PHONE HOME: () WORK: ()	
PRIMARY CARE MANAGER (PCM) MUST BE COMPLETED				NAME/CLINIC SITE				IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY CARE MANAGER'S ADDRESS				CITY		STATE		ZIP			
NAME		LAST		FIRST		MI		RELATIONSHIP TO SPONSOR		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS				(NOT A P.O. BOX)		CITY		STATE		ZIP	
MAILING ADDRESS				CITY		STATE		ZIP		PHONE HOME: () WORK: ()	
PRIMARY CARE MANAGER (PCM) MUST BE COMPLETED				NAME/CLINIC SITE				IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY CARE MANAGER'S ADDRESS				CITY		STATE		ZIP			

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PAYMENT METHOD - PLEASE INDICATE CHOICES

Active duty family members do not pay an enrollment fee. Retirees and family members, survivors and eligible former spouses do pay an enrollment fee.

Annual Payment ☐ \$230 Individual ☐ \$460 Family (Two or more)

Was payment made in another region? ☐ Yes ☐ No

If yes, indicate previous payment method: ☐ Quarterly ☐ Annual

If a quarterly fee is due now, complete the Quarterly Payment section below.

For Official Use Only

Amt. Rcvd. _____ Accepted by: _____

TSC Loc. _____ Date Rcvd. _____

Effective Date: _____

Quarterly Payment

1. You may pay your enrollment fee in quarterly or yearly installments. *If you are turning 65 during the enrollment year, quarterly payments may be your best option. If you lose eligibility when you turn 65, you will not receive a refund on enrollment fees. Check your TSC for eligibility details.*
2. You may elect to make a single quarterly payment at a time, or several quarterly payments in advance all at once.
3. When you select a quarterly payment option, the amount enclosed must match the quarterly option selected, or your application will be delayed.
4. When paying enrollment fees on a quarterly basis, you will receive an invoice 30 days prior to your next quarterly payment due date.
5. You can be disenrolled for nonpayment of your quarterly enrollment fees. If this occurs, you may not re-enroll in TRICARE Prime for a period of 12 months. You may use TRICARE Standard or TRICARE Extra during the lockout period.

Yes, I want to pay my TRICARE Prime enrollment fee on a quarterly basis. I selected the following payment option:

- ☐ **Option #1** 1st quarterly payment only (amount submitted must reflect this choice)
Retiree/Retiree Family Member(s) individual \$57.50 x 1 = \$57.50 Retiree/Retiree Family Member(s) Two or more: \$115.00 x 1 = \$115.00
- ☐ **Option #2** 1st and 2nd quarterly payment only (amount submitted must reflect this choice)
Retiree/Retiree Family Member(s) individual \$57.50 x 2 = \$115.00 Retiree/Retiree Family Member(s) Two or more: \$115.00 x 2 = \$230.00
- ☐ **Option #3** 1st, 2nd and 3rd quarterly payment only (amount submitted must reflect this choice)
Retiree/Retiree Family Member(s) individual \$57.50 x 3 = \$172.50 Retiree/Retiree Family Member(s) Two or more: \$115.00 x 3 = \$345.00

Method of Payment ☐ Check # _____ ☐ Cashier's Check ☐ Money Order *Make Check or Money Order payable to HNFS - TRICARE*
☐ VISA ☐ MasterCard Money Order #: _____

If paying by credit card, please complete the following:

Card Number: _____ Expiration Date: _____

Print name on card: _____ Signature: _____

BENEFICIARY INFORMATION REQUESTED

1. Do you or your family members requesting enrollment have other health coverage, including Medicare?
☐ Yes ☐ No If yes, complete Other Health Insurance Questionnaire*
**Failure to complete Other Health Insurance Questionnaire may cause delays in processing of Prime Enrollment Application and medical or pharmacy claims.*
2. Have you or any family members ever been enrolled under a different Social Security number?
☐ Yes ☐ No If yes, please give past Social Security Number _____

BENEFICIARY AGREEMENT: INITIAL THESE STATEMENTS AND SIGN BELOW

- _____ I have read the information provided to me in the TRICARE Prime and Extra brochure and hereby apply for enrollment. I understand that entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS).
- _____ I agree to keep the information for both myself and my family members current in DEERS and the Composite Health Care System (CHCS). This includes both address and family status information.
- _____ I understand that a Primary Care Manager (PCM) must be assigned/selected for each individual being enrolled. Failure to select a PCM may result in your application being delayed.
- _____ If I or a family member has any change in Other Health Insurance (OHI) information during my enrollment period in TRICARE Prime, I will immediately inform Health Net Federal Services.
- _____ I understand that, except for emergencies, all TRICARE Prime services must be coordinated through the PCM. If care is obtained that has not been coordinated by the PCM and authorized by the Health Care Finder, I understand that I will be responsible for payment of charges in accordance with the provisions of the Point-of-Service (POS) option as described in the TRICARE Program Benefits and Features brochure, Member Handbook and TRICARE regulations.
- _____ I understand that enrollment in TRICARE Prime is for 12 consecutive months and that I, and eligible enrolled family members may choose to disenroll after each 12-month enrollment period. An enrolled member who disenrolls after the 12-month enrollment period may re-enter at any time. An enrolled member who chooses to disenroll prior to completing the 12-month enrollment period for any reason other than Permanent Change of Station or a permanent move either within the region or to another region may not re-enroll for a period of 12-months **except for Active Duty Family Members whose sponsor is ranked E1-E4.**
- _____ I further understand that an enrolled member will be disenrolled for non-payment of a quarterly enrollment fee by the prescribed date, and if disenrolled, may not re-enroll for a period of 12 months. An enrolled member who disenrolls after the 12-month re-enrollment period, may re-enroll at any time.
- _____ I understand that the enrollment fee is non-refundable in all circumstances. I also understand that, if I am transferring my enrollment to a new TRICARE region, my Prime benefits will transfer with me. If I move to an area where TRICARE Prime is not available, however, I must disenroll and forfeit my enrollment fee.
- _____ If I selected the quarterly payment option, I hereby certify that I have read and understood the Quarterly Payment Application instructions and will abide by the option I have selected.
- _____ I authorize Health Net Federal Services and/or its provider network subcontractor(s) to examine, disclose and copy records of any physician, hospital or provider when necessary for quality management or proper payment of benefits for all enrollees listed on this application and/or attachment.
- _____ I understand that Health Net Federal Services reserves the right to require beneficiary prepayment of prescription drug costs and submittal of a claim for determination of payment of benefits, if I have other comprehensive health insurance.
- _____ I agree to waive the drive time if I select a Primary Care Manager that is more than a 30-minute drive from my residence.
- _____ I hereby certify that the information provided on the document is true and complete. I agree to abide by the provisions of membership in TRICARE Prime

SIGNATURE

RELATIONSHIP TO SPONSOR

DATE

AGENCY DISCLOSURE STATEMENT

Public reporting burden for this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to the Department of Defense, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4302; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington D.C. 20508. PLEASE DO NOT RETURN YOUR APPLICATION TO EITHER OF THESE ADDRESSES. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT

(1) **Authority:** 5 USC 552a; 10 USC 1079 and 1086, 58 FR 45318. (2) **Purpose:** To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR, Part 199.17). (3) **Uses:** Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) **Disclosure:** Voluntary; however, failure to provide information will result in the denial of enrollment.

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